FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040436

Facility Name: STERLING PAVILION

Address: 105 E. 23RD STREET (Number) STERLING (City) 61081 (Zip Code)

County: WHITESIDE

Telephone Number: (815) 626-4264 **Fax #** (815) 626-3254

IDPA ID Number: 363873072001

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) _____
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,165	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,151	5,037	2,272	11,460	8
9	SNF/PED					9
10	ICF	22,606	7,101	261	29,968	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,757	12,138	2,533	41,428	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.80%

D. How many bed-hold days during this year were paid by Public Aid?
205 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 121 and days of care provided 2,269

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	158,068	12,679	9,120	179,867		179,867		179,867			1
2	Food Purchase		168,515		168,515		168,515	(1,173)	167,342			2
3	Housekeeping	114,760	26,493		141,253		141,253		141,253			3
4	Laundry	58,547	28,191		86,738		86,738		86,738			4
5	Heat and Other Utilities			118,598	118,598		118,598	907	119,505			5
6	Maintenance	53,955	46,878	35,760	136,593		136,593	(1,687)	134,906			6
7	Other (specify):*							603	603			7
8	**TOTAL General Services**	385,330	282,756	163,478	831,564		831,564	(1,350)	830,214			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,376,554	75,554	30,186	1,482,294		1,482,294	(211)	1,482,083			10
10a	Therapy	89,030		7,191	96,221		96,221		96,221			10a
11	Activities	66,621	1,570		68,191		68,191		68,191			11
12	Social Services	46,665		6,907	53,572		53,572		53,572			12
13	Nurse Aide Training			676	676		676		676			13
14	Program Transportation			100	100		100		100			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,578,870	77,124	45,060	1,701,054		1,701,054	(211)	1,700,843			16
	C. General Administration											
17	Administrative	84,580			84,580		84,580	172,361	256,941			17
18	Directors Fees											18
19	Professional Services			300,352	300,352		300,352	(269,276)	31,076			19
20	Dues, Fees, Subscriptions & Promotions			44,808	44,808		44,808	(33,275)	11,533			20
21	Clerical & General Office Expenses	38,046	5,147	37,558	80,751		80,751	32,050	112,801			21
22	Employee Benefits & Payroll Taxes			392,780	392,780		392,780		392,780			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,834	1,834		1,834	241	2,075			24
25	Other Admin. Staff Transportation			2,120	2,120		2,120	(386)	1,734			25
26	Insurance-Prop.Liab.Malpractice			103,970	103,970		103,970	7,758	111,728			26
27	Other (specify):*							24,960	24,960			27
28	**TOTAL General Administration**	122,626	5,147	883,422	1,011,195		1,011,195	(65,567)	945,628			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,086,826	365,027	1,091,960	3,543,813		3,543,813	(67,128)	3,476,685			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number STERLING PAVILION #0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,693	51,693		51,693	134,682	186,375			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,447	23,447		23,447	652,195	675,642			32
33	Real Estate Taxes			29,503	29,503		29,503	2,637	32,140			33
34	Rent-Facility & Grounds			668,141	668,141		668,141	(668,141)				34
35	Rent-Equipment & Vehicles			2,722	2,722		2,722	7,580	10,302			35
36	Other (specify):*											36
37	TOTAL Ownership			775,506	775,506		775,506	128,953	904,459			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,514	19,260	72,774		72,774	(575)	72,199			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,247	66,247		66,247		66,247			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		53,514	85,507	139,021		139,021	(575)	138,446			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,086,826	418,541	1,952,973	4,458,340		4,458,340	61,250	4,519,590			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(24,599)	30		9
10	Interest and Other Investment Income	(23,447)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(489)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,661)	21		18
19	Entertainment				19
20	Contributions	(8,210)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,996)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,226)	20		28
29	Other-Attach Schedule	(24,119)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (112,747)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	173,997		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 173,997		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 61,250		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

STERLING PAVILION

ID# 0040436

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PPA-NURSING SUPPLIES	$ (88)	10	1
2	PPA-ADVERTISING AND PROMOTION	(611)	20	2
3	PPA-TRAVEL	(386)	25	3
4	PPA-INSURANCE	(1,894)	26	4
5	PPA-R&M	(1,346)	06	5
6	PPA-EQUIPMENT RENTAL	(134)	35	6
7	ACCOUNT COLLECTION FEES	(765)	21	7
8	PRIOR PERIOD REPLACEMENT TAX	3	21	8
9	COLLECTION FEES	(301)	21	9
10	DISCOUNTS EARNED	(684)	02	10
11	NONCARE ASSET DEPRECIATION	(6,572)	30	11
12	BUILDING RENTAL	(145)	34	12
13	ICLTC COPE DUES	(1,848)	20	13
14	CAPITALIZED R&M	(9,348)	6	14
15				15
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99				99
100				100
101	Total	(24,119)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1,173)											(1,173)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			907									907	5
6	Maintenance	(10,694)		2,779	6,228								(1,687)	6
7	Other (specify):*			73		530							603	7
8	**TOTAL General Services**	(11,867)		3,759	6,228	530							(1,350)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(88)						(123)					(211)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(88)						(123)					(211)	16
	C. General Administration													
17	Administrative				172,361								172,361	17
18	Directors Fees													18
19	Professional Services			(269,157)			(119)						(269,276)	19
20	Fees, Subscriptions & Promotions	(33,891)		616									(33,275)	20
21	Clerical & General Office Expenses	(9,724)	16	36,142	5,616								32,050	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			241									241	24
25	Other Admin. Staff Transportation	(386)											(386)	25
26	Insurance-Prop.Liab.Malpractice	(1,894)	6,667	2,985									7,758	26
27	Other (specify):*			6,212		18,748							24,960	27
28	**TOTAL General Administration**	(45,895)	6,683	(222,961)	177,977	18,748	(119)						(65,567)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(57,850)	6,683	(219,202)	184,205	19,278	(119)	(123)					(67,128)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number STERLING PAVILION # 0040436 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(31,171)	161,762	4,091									134,682	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(23,447)	672,043	3,599									652,195	32
33	Real Estate Taxes			2,637									2,637	33
34	Rent-Facility & Grounds	(145)	(667,996)										(668,141)	34
35	Rent-Equipment & Vehicles	(134)		7,714									7,580	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(54,897)	165,809	18,041									128,953	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(262)	(313)					(575)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(262)	(313)					(575)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(112,747)	172,492	(201,161)	184,205	19,278	(381)	(436)					61,250	45

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ATTACHED		SEE ATTACHED		SEE ATTACHED		
				STERLING BUILDING PAVILION, LLC		BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 667,996	STERLING BUILDING, LLC		$	$ (667,996)	1
2	V	32	INTEREST EXPENSE		STERLING BUILDING, LLC		672,043	672,043	2
3	V	30	DEPRECIATION EXPENSE		STERLING BUILDING, LLC		161,762	161,762	3
4	V	26	AMORTIZATION EXPENSE		STERLING BUILDING, LLC		6,667	6,667	4
5	V	21	BANK CHARGES		STERLING BUILDING, LLC		16	16	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 667,996			$ 840,488	$ * 172,492	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 907	$ 907	15
16	V	6	REPAIRS & MAINT.				2,779	2,779	16
17	V	7	EMP.BEN. - GEN. SERVICES				73	73	17
18	V	19	PROFESSIONAL FEES				1,843	1,843	18
19	V	20	DUES AND SUBSCRIPTIONS				616	616	19
20	V	21	CLERICAL & GENERAL				36,142	36,142	20
21	V	24	SEMINARS AND TRAVEL				241	241	21
22	V	26	INSURANCE				2,985	2,985	22
23	V	27	EMP.BEN. - GEN. ADMIN.				6,212	6,212	23
24	V	30	DEPRECIATION				4,091	4,091	24
25	V	32	INTEREST				3,599	3,599	25
26	V	33	REAL ESTATE TAXES				2,637	2,637	26
27	V	35	EQUIPMENT RENTAL				7,714	7,714	27
28	V	19	BOOKKEEPING SERVICES	271,000				(271,000)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 271,000			$ 69,839	$ * (201,161)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 6,228	$ 6,228	15
16	V	10	NURSING CMP - SUE G.						16
17	V	17	ADMIN. CMP. - M. MAUER				34,858	34,858	17
18	V	17	ADMIN. CMP. - M. AARON				51,483	51,483	18
19	V	17	ADMIN. CMP. - F. AARON				34,367	34,367	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN						20
21	V	17	ADMIN. CMP. - S. KOPLIN				9,898	9,898	21
22	V	17	ADMIN. CMP. - D. MAGAFAS				11,639	11,639	22
23	V	17	ADMIN. CMP. - E. CASSON						23
24	V	17	ADMIN. CMP. - S. BOGEN						24
25	V	17	ADMIN. CMP. - S. LEVY				13,488	13,488	25
26	V	17	ADMIN. CMP. - HOWARD ALTER						26
27	V	17	ADMIN. CMP. - NON-OWNER				16,628	16,628	27
28	V	21	CLERICAL CMP. - S. AARON				5,616	5,616	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 184,205	$ * 184,205	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 530	$ 530	15
16	V	15	EMP. BEN.- SUE G.						16
17	V	27	EMP. BEN.- M. MAUER				1,515	1,515	17
18	V	27	EMP. BEN.- M. AARON				1,929	1,929	18
19	V	27	EMP. BEN.- F. AARON				5,077	5,077	19
20	V	27	EMP. BEN.- S. GOLDSTEIN						20
21	V	27	EMP. BEN.- S. KOPLIN				3,133	3,133	21
22	V	27	EMP. BEN.- D. MAGAFAS				1,614	1,614	22
23	V	27	EMP. BEN.- E. CASSON						23
24	V	27	EMP. BEN.- S. BOGEN						24
25	V	27	EMP. BEN.- S. LEVY				1,947	1,947	25
26	V	27	EMP. BEN.- HOWARD ALTER						26
27	V	27	EMP. BEN.- NON-OWNER				2,479	2,479	27
28	V	27	EMP. BEN. - S. AARON				1,054	1,054	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 19,278	$ * 19,278	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$ 41	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 41	$	15
16	V	19	PROFESSIONAL FEES	6,600	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	6,481	(119)	16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES	14,585	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	14,323	(262)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,226			$ 20,845	$ * (381)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	855	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	732	$ (123)	15
16	V	39	ANCILLARY EXPENSE	2,173	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	1,860	(313)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,028			$ 2,592	$ * (436)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MAURICE AARON	OWNER	ADMIN	22.23%	SEE ATTACHED	4.22	8.44%	Dynamic Sal	$ 51,483	17-7	1
2	MARSHALL MAUER	OWNER	ADMIN	8.26%	SEE ATTACHED	3.84	7.68%	Dynamic Sal	34,858	17-7	2
3	SUE KOPLIN	OWNER	ADMIN	0.39%	SEE ATTACHED	5.53	13.84%	Dynamic Sal	9,898	17-7	3
4	DIANIA MAGAFAS	OWNER	ADMIN	0.39%	SEE ATTACHED	5.99	13.32%	Dynamic Sal	11,639	17-7	4
5	DENNIS NEHNER	OWNER	MAINTENANCE	0.39%	SEE ATTACHED	4.22	10.56%	Dynamic Sal	6,228	6-7	5
6	SHARON AARON	RELATIVE	CLERICAL	0.00%	SEE ATTACHED	3.84	9.59%	Dynamic Sal	5,616	17-7	6
7	FRED AARON	OWNER	ADMIN	23.80%	SEE ATTACHED	8	20.00%	Dynamic Sal	34,367	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 154,089		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	441,841	13	$ 9,671	$	41,428	$ 907	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	441,841	13	29,639	3,380	41,428	2,779	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	441,841	13	778		41,428	73	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	441,841	13	19,651		41,428	1,843	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	441,841	13	6,566		41,428	616	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	441,841	13	385,463	300,175	41,428	36,142	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	441,841	13	2,576		41,428	241	7
8	26	INSURANCE	PATIENT DAYS	441,841	13	31,835		41,428	2,985	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	441,841	13	66,254		41,428	6,212	9
10	30	DEPRECIATION	PATIENT DAYS	441,841	13	43,634		41,428	4,091	10
11	32	INTEREST	PATIENT DAYS	441,841	13	38,384		41,428	3,599	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	441,841	13	28,121		41,428	2,637	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	441,841	13	82,269		41,428	7,714	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 744,841	$ 303,555		$ 69,839	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	10	59,032	59,032	4	6,228	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	32,744	32,744			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	12	363,103	363,103	4	34,858	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	10	487,988	487,988	4	51,483	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	193,312	193,312	8	34,367	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	37	2	153,497	153,497			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	8	71,542	71,542	6	9,898	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	87,437	87,437	6	11,639	8
9	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	38	1	31,246	31,246			9
10	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	2	54,060	54,060			10
11	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	12	140,632	140,632	4	13,488	11
12	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	12	157,563	157,563	5	16,628	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	12	58,502	58,502	4	5,616	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,902,658	$ 1,902,658		$ 184,205	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	10	5,020		4	530	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40	1	3,128				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	12	15,782		4	1,515	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	10	18,288		4	1,929	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	6	28,556		8	5,077	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	37	2	25,672				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	8	22,644		6	3,133	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	12,125		6	1,614	8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	38	1	3,418				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45	2	5,010				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	12	20,299		4	1,947	11
12	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,296				12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	12	23,491		5	2,479	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	12	10,982		4	1,054	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 195,711	$		$ 19,278	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						41	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION						6,481	2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION						14,323	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 20,845	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						732	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						1,860	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,592	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	STERLING PAVILION BLDG	X		CAPITALIZED LEASE			$	$ 6,721,407			$ 672,042	1
2	MANUFACTURERS BANK		X	NOTE PAYABLE				21,623				2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURERS BANK		X	LINE OF CREDIT				345,000			21,376	6
7				INSURANCE FINANCING							2,071	7
8												8
9	TOTAL Facility Related						$	$ 7,088,030			$ 695,489	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	INTEREST INCOME										(23,447)	11
12	ALLOC. DYNAMIC										3,599	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (19,848)	14
15	TOTALS (line 9+line14)						$	$ 7,088,030			$ 675,641	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	30,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	32,140	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,140	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	32,140	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	29,954	8
1998	29,403	9
1999	28,961	10
2000	29,219	11
2001	29,503	12

ACCRUAL = 2001 TAX X 1.02
29503 X 1.02 = 30000 (ROUNDED)
DYNAMIC ALLOCATION - $2450

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STERLING PAVILION COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0040436

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-16-402-001	LONG TERM CARE PROPERTY	$ 28,378.24	$ 28,378.24
2.	11-16-402-013	LONG TERM CARE PROPERTY	$ 1,124.84	$ 1,124.84
3.	10-23-404-059-000	HOME OFFICE ALLOCATION	$ 26,130.18	$ 2,450.02
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 55,633.26	$ 31,953.10

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME STERLING PAVILION COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0040436

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,000 B. General Construction Type: Exterior BRICK Frame STEEL/CONCRETE Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILTY			$ 48,888	1
2	STERLING BLDG CO			100,000	2
3	TOTALS			$ 148,888	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1993	$ 6,052,408	$ 155,190	35	$ 115,190	$ (40,000)	$ 115,190	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	18,723		20	938	938	9,005	9
10	Various			1994	6,356		20	319	319	2,739	10
11	Various			1995	13,538		20	677	677	4,956	11
12	Various			1996	33,635		20	1,681	1,681	10,566	12
13	Various			1997	65,081		20	3,255	3,255	17,638	13
14	Various			1998	86,428		20	4,323	4,323	19,135	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		41,593	1,066		1,188	122	11,091	68
69	Financial Statement Depreciation			51,693			(51,693)		69
70	TOTAL (lines 4 thru 69)		$ 6,317,762	$ 207,949		$ 127,571	$ (80,378)	$ 190,320	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,317,762	$ 207,949		$ 127,571	$ (80,378)	$ 190,320	1
2	CEILING TILES	1999	601		20	30	30	120	2
3	CONCRETE BLOCK WALLS	1999	3,142		20	157	157	628	3
4	WATER TREATMENT SYS	1999	6,890		20	345	345	1,380	4
5	GAS WATER HEATER	1999	8,935		20	447	447	1,788	5
6	DYNALOCK SYSTEM	1999	4,966		20	248	248	971	6
7	PIPES	1999	526		20	13	13	51	7
8	PIPES	1999	1,550		20	78	78	306	8
9	PIPES	1999	198		20	10	10	39	9
10	HANDRAIL	1999	2,393		20	120	120	460	10
11	TILE	1999	135		20	7	7	27	11
12	ACT/NURSE STATION	1999	1,128		20	56	56	215	12
13	ACT/NURSE STATION	1999	1,076		20	54	54	207	13
14	DRYWALL	1999	1,525		20	76	76	279	14
15	AIR CONDITIONER	1999	5,533		20	277	277	993	15
16	CAMERA SYSTEM	1999	2,500		20	125	125	458	16
17	ACT/NURSE STATION	1999	2,500		20	125	125	479	17
18	TILING	1999	3,513		20	176	176	601	18
19	DRAPES	1999	2,117		20	106	106	353	19
20	ACTIVITY ROOM	1999	935		20	47	47	157	20
21	ACTIVITY ROOM REMOD	1999	828		20	41	41	137	21
22	WATER SERVICE	1999	2,469		20	123	123	410	22
23	WATER SERVICE	1999	98		20	5	5	17	23
24	WATER MAIN REPLACE	1999	940		20	47	47	153	24
25	REMODELING	1999	1,154		20	58	58	189	25
26	WATER MAIN INSTALL	1999	238		20	12	12	39	26
27	NURSES STATION	1999	6,244		20	312	312	988	27
28	WALL	1999	801		20	21	21	64	28
29	LANDSCAPING	1999	705		20	35	35	140	29
30	PARKING BLOCKS	1999	1,025		20	51	51	170	30
31	WALLPAPER	1999	885		20	44	44	172	31
32	WALLPAPER	1999	5,367		20	268	268	1,050	32
33	PAINTING	1999	875		20	44	44	172	33
34	TOTAL (lines 1 thru 33)		$ 6,389,554	$ 207,949		$ 131,129	$ (76,820)	$ 203,533	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,389,554	$ 207,949		$ 131,129	$ (76,820)	$ 203,533	1
2	COVE BASE	1999	339		20	17	17	67	2
3	WALLPAPER	1999	880		20	44	44	154	3
4	WALLPAPER	1999	690		20	35	35	120	4
5	WALLPAPER	1999	1,729		20	86	86	301	5
6	GENERATOR	1999	579		20	29	29	116	6
7	OVEN REPAIR	1999	613		20	31	31	119	7
8	FIRE ALARM	1999	560		20	28	28	107	8
9	PLUMBING	1999	595		20	30	30	100	9
10	MIRRORS	2000	481		20	24	24	72	10
11	CUBICLE CURTAINS	2000	1,036		20	52	52	143	11
12	COUNTER TOPS	2000	485		20	24	24	64	12
13	FLOOR TILES	2000	549		20	27	27	72	13
14	DRYWALL	2000	490		20	25	25	67	14
15	INSTALL THERMOSTAT	2000	1,856		20	93	93	233	15
16	NURSE STATION CAMERA	2000	1,975		20	99	99	239	16
17	DRYWALL	2000	862		20	43	43	104	17
18	FREEZER DOOR & FRAME	2000	1,153		20	58	58	121	18
19	PAINTING & DECORATIN	2000	3,035		20	152	152	304	19
20	CARPETING	2001	934		20	47	47	94	20
21	TILE	2001	558		20	28	28	56	21
22	SPRINKLER SYSTEM REP	2001	2,002		20	100	100	175	22
23	DYNA LOCKS	2001	5,085		20	254	254	423	23
24	OVERBED LIGHT	2001	1,098		20	55	55	92	24
25	EMERGENCY LIGHTS	2001	365		20	18	18	30	25
26	SMOKE DETECTORS	2001	1,083		20	54	54	90	26
27	PARKING CURB	2001	1,023		20	51	51	81	27
28	DOOR	2001	1,133		20	57	57	86	28
29	CEILING TILE INSTALL	2001	1,035		20	52	52	78	29
30	SEALER FOR PARKING L	2001	445		20	22	22	33	30
31	FENCE	2001	292		20	15	15	23	31
32	PARKING LOT PAINTING	2001	785		20	39	39	62	32
33	REPAIR WALLS	2001	1,285		20	64	64	91	33
34	TOTAL (lines 1 thru 33)		$ 6,424,584	$ 207,949		$ 132,882	$ (75,067)	$ 207,450	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,424,584	$ 207,949		$ 132,882	$ (75,067)	$ 207,450	1
2	DOORS	2001	527		20	26	26	35	2
3	CIRCUIT BRD-DYNALOC	2001	1,170		20	59	59	69	3
4	SHOP SINK BASINS	2001	969		20	48	48	56	4
5	SHOP SINK BASINS	2001	420		20	21	21	25	5
6	SHOP SINK BASINS	2001	515		20	26	26	28	6
7	PLUMBING	2001	532		20	27	27	38	7
8	TELE. SYS.- TRI-CITY	2001	9,890		20	495	495	660	8
9	GARAGE	2002	54,605		20	4,550	4,550	4,550	9
10	WALL HEATER	2002	504		20	46	46	46	10
11	PHONE WIRING GARAGE	2002	950		20	63	63	63	11
12	WALL VINYL	2002	4,190		20	244	244	244	12
13	REFRIGERATOR COMPRESSOR	2002	715		20	42	42	42	13
14	FLOORING	2002	832		20	42	42	42	14
15	DRAIN PIPING	2002	887		20	44	44	44	15
16	ROOFTOP COMPRESSORS	2002	3,423		20	171	171	171	16
17	ROOFTOP COMPRESSOR	2002	1,502		20	63	63	63	17
18	KEYPADS FOR DOORS	2002	1,486		20	74	74	74	18
19	BLINDS	2002	1,683		20	84	84	84	19
20	BLINDS	2002	340		20	14	14	14	20
21	BLINDS	2002	289		20	12	12	12	21
22	WINDOW TREATMENTS	2002	9,612		20	320	320	320	22
23	CIRCUIT BOARD SECURITY	2002	1,256		20	42	42	42	23
24	COUNTERTOPS	2002	1,925		20	64	64	64	24
25	WALL VINYL	2002	1,294		20	32	32	32	25
26	FIREPLACE	2002	1,761		20	44	44	44	26
27	HANDRAILS & BUMPERS	2002	4,624		20	39	39	39	27
28	PAINTING & DECORATIN	2002	533		20	27	27	27	28
29	WALLPAPER	2002	585		20	29	29	29	29
30	WALLPAPER	2002	2,436		20	122	122	122	30
31	AC REPAIRS	2002	545		20	27	27	27	31
32	AC REPAIRS	2002	1,708		20	85	85	85	32
33	VALVE REPAIRS	2002	981		20	49	49	49	33
34	TOTAL (lines 1 thru 33)		$ 6,537,273	$ 207,949		$ 139,913	$ (68,036)	$ 214,690	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,537,273	$ 207,949		$ 139,913	$ (68,036)	$ 214,690	1
2	MOTOR	2002	1,200		20	60	60	60	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,538,473	$ 207,949		$ 139,973	$ (67,976)	$ 214,750	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 41,593	$ 1,066	35	$ 1,188	$ 122	$ 11,091	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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22											22
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24											24
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 41,593	$ 1,066		$ 1,188	$ 122	$ 11,091	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 253,793	$ 1,536	$ 25,208	$ 23,672	10	$ 125,591	71
72	Current Year Purchases	38,182		2,385	2,385	10	2,385	72
73	Fully Depreciated Assets	378,127				10	378,127	73
74								74
75	TOTALS	$ 670,102	$ 1,536	$ 27,593	$ 26,057		$ 506,103	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	2000	$ 45,441	$	$ 15,147	$ 15,147	5	$ 41,654	76
77		ALLOC. DYNAMIC	1900	5,278	1,489	3,662	2,173	5	5,421	77
78										78
79										79
80	TOTALS			$ 50,719	$ 1,489	$ 18,809	$ 17,320		$ 47,075	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,408,182	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 210,974	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 186,375	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,599)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 767,928	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SECTION 754-LAND - 1900	$ 4,235	$	$	86
87	SECTION 754-BLDG - 1900	256,308	6,572	13,966	87
88					88
89					89
90					90
91	TOTALS	$ 260,543	$ 6,572	$ 13,966	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,588 Description: $2588 - COPIER
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ALLOC. DYNAMIC		$	$ 7,714	17
18					18
19					19
20					20
21	TOTAL		$	$ 7,714	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$ 576	$	$	$ 576
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	100			100
9	TOTALS	$ 676	$	$	$ 676
10	SUM OF line 9, col. 1 and 2 (e)	$ 676			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,675			4,675	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			14,585			14,585	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				43,748		43,748	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						9,766		9,766	13
14	TOTAL			$		$ 19,260	$ 53,514		$ 72,774	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,191	$ 2,191	1
2	Cash-Patient Deposits	15,989	15,989	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	590,433	590,433	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,021	40,021	6
7	Other Prepaid Expenses	822	822	7
8	Accounts Receivable (owners or related parties)	200,000	200,001	8
9	Other(specify): See Supplemental Schedule	29,513	41,613	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 878,969	$ 891,070	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		104,234	13
14	Buildings, at Historical Cost		6,308,716	14
15	Leasehold Improvements, at Historical Cost	426,663	426,663	15
16	Equipment, at Historical Cost	335,599	698,599	16
17	Accumulated Depreciation (book methods)	(301,941)	(1,991,556)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,498	6,498	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,498)	(6,498)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	233,098	46,528	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 693,419	$ 5,593,184	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,572,388	$ 6,484,254	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 276,982	$ 276,982	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,989	15,989	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,574	207,574	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,179	2,179	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,000	30,000	32
33	Accrued Interest Payable	1,605	1,605	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	7,413	7,413	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	121	121	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 541,863	$ 541,863	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	366,623	366,623	39
40	Mortgage Payable		6,721,407	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 366,623	$ 7,088,030	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 908,486	$ 7,629,893	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 663,902	$ (1,145,639)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,572,388	$ 6,484,254	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 690,724	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 690,724	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	45,778	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(72,600)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (26,822)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 663,902	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,431,138	1
2	Discounts and Allowances for all Levels	(369,444)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,061,694	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	325,270	6
7	Oxygen	2,973	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 328,243	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	66,416	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,104	19
20	Radiology and X-Ray	6,905	20
21	Other Medical Services	12,769	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 89,194	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,303	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,303	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	684	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 684	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,504,118	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	831,564	31
32	Health Care	1,701,054	32
33	General Administration	1,011,195	33
	B. Capital Expense		
34	Ownership	775,506	34
	C. Ancillary Expense		
35	Special Cost Centers	72,774	35
36	Provider Participation Fee	66,247	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,458,340	40
41	**Income before Income Taxes (line 30 minus line 40)****	45,778	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 45,778	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,044	2,197	$ 60,520	$ 27.55	1
2	Assistant Director of Nursing	1,861	2,078	49,931	24.03	2
3	Registered Nurses	8,250	8,702	158,858	18.26	3
4	Licensed Practical Nurses	19,902	21,385	339,577	15.88	4
5	Nurse Aides & Orderlies	72,845	77,279	751,273	9.72	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,429	3,674	89,030	24.23	8
9	Activity Director					9
10	Activity Assistants	7,838	8,177	66,621	8.15	10
11	Social Service Workers	3,847	4,086	46,665	11.42	11
12	Dietician					12
13	Food Service Supervisor	1,910	2,115	22,844	10.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,717	19,399	135,224	6.97	15
16	Dishwashers					16
17	Maintenance Workers	4,213	4,382	53,955	12.31	17
18	Housekeepers	13,366	14,591	114,760	7.87	18
19	Laundry	8,294	8,833	58,547	6.63	19
20	Administrator	1,925	2,174	84,580	38.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,479	2,767	38,046	13.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,797	2,058	16,395	7.97	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	172,717	183,897	$ 2,086,826 *	$ 11.35	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	186	$ 7,120	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	59	1,896	10-03	38
39	Pharmacist Consultant	106	4,230	10-03	39
40	Physical Therapy Consultant	1	41	10a-03	40
41	Occupational Therapy Consultant	MONTHLY	7,150	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	120	6,907	12-03	45
46	Other(specify)				46
47	FOOD PURCHASING AGENT	MONTHLY	2,000	01-03	47
48	NURSE CONS. - DART CHARTS	MONTHLY	24,060	10-03	48
49	TOTAL (lines 35 - 48)	472	$ 53,404		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RHONDA REED	ADMINISTRATOR	0	$ 84,580
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 84,580

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
ECONOCARE, INC.	PURCHASING SERVICES	$ 2,178
PERSONNEL PLANNERS, INC	UNEMPLOYEMENT CONS	3,459
HEALTH DATA SYSTEMS, INC	DATA PROCESSING	3,352
DYNAMIC HEALTHCARE	BOOKKEEPING SVCS	271,000
FR&R	ACCOUNTING FEES	14,608
SACHNOFF & WEAVER	LEGAL FEES	5,755
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 300,352

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,333
Unemployment Compensation Insurance	20,385
FICA Taxes	156,498
Employee Health Insurance	141,800
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS	7,764
TOTAL (agree to Schedule V, line 22, col.8)	$ 392,780

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,969
Health Care Worker Background Check	560
(Indicate # of checks performed 80)	
DUES AND SUBSCRIPTIONS	5,614
LICENSES AND PERMITS	1,163
ADVERSITING AND PROMOTION	23,833
ALLOC. DYNAMIC	616
Less: Public Relations Expense	( )
Non-allowable advertising	(20,995)
Yellow page advertising	(2,226)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,534

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,834
ALLOC. DYNAMIC	241
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,075

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number STERLING PAVILION # 0040436 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **ICLTC - $6258**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,373** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,247**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees